







# Allied Healthcare

### **Scholarship Program Application**

Made possible through funding from Kaiser Permanente

# Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in rural and urban areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities

# **Application Instructions**



The Allied Healthcare Scholarship Program is offered to students enrolled or accepted in an allied healthcare education program. Students who attend a community college program are eligible for a scholarship up to \$2,500. Students who attend a university program are eligible for a scholarship up to \$3,000.

Applications for the Allied Healthcare Scholarship are accepted biannually in March and September. Scholarships funded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the student's allied healthcare education. All awards are subject to the availability of funding.

The purposes of the Allied Healthcare Scholarship are: 1) to encourage allied healthcare professionals to practice direct patient care in a medically underserved area of California; 2) to increase the number of appropriately trained allied healthcare professionals; and 3) to encourage underrepresented groups to pursue the allied healthcare profession.

Although this scholarship is funded by Kaiser Permanente, awardees of this program are not obligated to work for Kaiser Permanente.

#### **SELECTION CRITERIA**

Selection for the Allied Healthcare Scholarship is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

**Work Experience -** allied healthcare and non-allied healthcare work experience in a medically underserved area (MUA).

**Financial Need -** actual or potential financial difficulty in completing education in the absence of the scholarship.

**Career Goals -** professional goals for the next five to ten years.

**Community Service** - documented volunteer service and/or activities, particularly in a MUA.

**Community Background -** family structure and community where you grew up; for example, rural, inner city/urban, suburban, or MUA.

**Academic Performance -** prior and current academic performance; potential for future academic success.

**Priority will be given to:** Students who will complete their allied healthcare program within the next two years. Awards are made on a competitive basis.

### **Scholarship Eligibility**

To be eligible for a scholarship, students must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

**Graduation Requirements:** Your graduation date may impact the amount of funding you are eligible to receive.

Be enrolled or accepted in one of the following allied healthcare programs: Diagnostic Medical Sonography, Medical Imaging, Medical Laboratory Technology, Occupational Therapy, Pharmacy, Pharmacy Technician, Physical Therapy, Respiratory Care, Social Work, Surgical Technician, Radiologic Technology, Radiation Therapy Technology, Nuclear Medicine Technology, and Clinical Laboratory Science.

Nursing students are not eligible to apply for this program. Please visit the Foundation's web site at www.healthprofessions.ca.gov and download the Associate or Baccalaureate Degree Nursing Scholarship Application for eligibility information.

**Be a full-time or part-time student** (no less than 6 units) in a California accredited school.

**Immediately following graduation**, complete a 1-year service obligation to work in a medically underserved area of California providing direct patient care in your field of study.

### Or

Immediately following graduation, complete 100 volunteer work hours for every \$2,500 scholarship or 150 volunteer work hours for every \$3,000 scholarship.

Maintain a minimum cumulative GPA of 2.0 each year funds are received.

**Be a U.S. citizen** or **permanent resident** and a California resident.

# Application Instructions (continued)



### SCHOLARSHIP APPLICATION

Submit the following:

### 1. Official Transcript(s) related to your allied healthcare education

If you are a student in your first year of the program and your transcripts do not reflect your allied healthcare education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

2. Personal Statements (Part D of the Application)
Attach your personal statements to the application. Your statements must be typed. Please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.

#### 3. Two letters of recommendation

Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member. Letters of recommendation that confirm community service are encouraged.

### 4. Graduation Date Verification Form

The program director or a faculty member authorized to sign on the director's behalf must sign this form. The Graduation Date Verification Form is enclosed as part of the scholarship application. Students can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

### **5. Resume** (optional)

If available, please attach a copy of your resume.

### 6. Student Aid Report (SAR)

Students must submit the final 2007-2008 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html.

Or

#### 2006 Federal Tax Return with all W-2s

Students who do not apply for financial aid must submit complete copies of their 2006 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

#### **APPLICATION SUBMISSION**

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify students if their application is received incomplete. Students are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

#### **NOTIFICATION OF AWARDS**

The Foundation will notify students of their application results within eight weeks of the final filing date.

SPRING APPLICATION POSTMARK DEADLINE: MARCH 24, 2007 FALL APPLICATION POSTMARK DEADLINE: SEPTEMBER 11, 2007

### **SUBMIT APPLICATIONS TO:**

Health Professions Education Foundation Allied Healthcare Scholarship Program 818 K Street, Suite 210 Sacramento, CA 95814 (800) 773-1669 or (916) 324-6500

## Allied Healthcare Scholarship Program Application



Do you owe an existing service obligation to another entity?	Yes	■No	
(If yes, previous obligations must be completed before applying)			_

	instructions when completing the application. Compl applications and all supporting documents must be po				nts are sub-
	ONAL INFORMATION Inswers in the space provided) Applicants may ng this application.	List any languages you can s to English. Check all that app	•	vrite in additi	on
lame:		1		eak Read	Write
Mailing Address:		2	🗆 sp	eak Read	Write
Dity:	State: Zip:	Are you a citizen or permane (If no, do not continue. You must b			
County:		Are you a California resident	<b>!?</b>	□Y€	es 🗆 No
Permanent Address:		PART B – WORK E	EXPERIENC	E	
City:	State: Zip:	Please list all paid and/or un	paid work experie	nce you have	
County:		List most recent employer fit 5 (maximum of 5 employers)		nai work mst	ory on pag
	Work Phone:	Employer's Name:			
Social Security #	CA Drivers License #	Address:			
Date of birth:// Age	: Gender: Male Female	City:	Staf	te: Zip	):
Marital Status: Un	married Married	County:			
Number of dependents other As declared on tax returns or stude	r than self and spouse:	Your Supervisor's Name:	Offi	ce Phone:	
	e of the Foundation?	Your Position/title:	Mor	nthly Salary:_	
	ract#	☐ Paid worker <b>OR</b> ☐ Non	ı-paid 🔲 Full-tin	ne <b>OR</b> 🗆 F	'art-time
Are you currently employe	d as a licensed health professional?	Employment Start Date//	/ Employment E	nd Date:/_	
f yes, provide license #	Expiration date//_	Average hours worked (please	choose only one):		
Are you the first in your fa	mily to attend college?	/day/week	_/ month		
Vhich best describes your ☐ Asian American ☐	r <b>ethnic background:</b> Pacific Islander	Brief description of your job du	ities:		
_	Native American  Hispanic/Latino				
Other (Please specify)					
f Native American, please s	pecify tribal affiliation and submit verification:				
	FOR OFFICIA	L USE ONLY			
Recd:	Compl / Inc:	Omitted: App Pgs GDV EV	/F SAR T/	AX LoR	Oth
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FOR OFFICIAL USE ONLY							
Recd:	Compl / Inc:	Omitted: App Pgs GDV	EVF	SAR	TAX	LoR	Oth
App Inquiry: (	) ( )	HPEF Contact:	for	:			
Input By:	MUA: Yes / No	CT#:					
Reviewed By:		Comments:					

### Allied Healthcare Scholarship Program Application



### PART C - COMMUNITY BACKGROUND

For each age category below, list the city, county, and state you grew up in. Check all items that best describe your socioeconomic background.

Age Category	Rural	Inner City/Urban	Suburban		Poor	Middle-class	Upperclass
Birth-10 years City:			ounty:				State:
Age Category 11-20 years City:	Rural	Inner City/Urban	Suburban  Dunty:		Poor		Upperclass State:
Age Category 21-30 years City:	Rural	Inner City/Urban	Suburban  Dunty:		Poor		Upperclass  State:
Age Category 31-40 years City:	Rural	Inner City/Urban	Suburban  Dunty:		Poor		Upperclass  State:
Age Category 41+ years City:	Rural	Inner City/Urban	Suburban  Dunty:		Poor		Upperclass State:

### PART D - PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

- 1. What kind of work would you like to do immediately after graduation?
- 2. What kind of work do you think you'll be doing in five years?
- 3. What is your vision of your professional future in ten years?
- 4. Describe any community service, volunteer activities, or club memberships within the past two years. Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.
- 5. Briefly describe your family background including: your father's and mother's occupation, annual income, marital status, and number of dependents including yourself.
- 6. Describe how your background is relevant to your interest in pursuing an allied health profession career. Do you see your background as an advantage, disadvantage or both?

### PART E - QUESTIONNAIRE

Where did you hear about the Allied Healthcare Scholarship Program?

(Check all that apply)

☐ School ☐ Work (employer or co-worker) ☐ Friend/Acquaintance
☐ Foundation Web site ☐ Other Web site ☐ Advertisement ☐ TV ☐ Radio

# □ Newspaper or publication (please specify) \_\_\_\_\_ □ Organization or Affiliation (please specify) \_\_\_\_\_ □ Other source (please specify)

Where did you receive the Allied Healthcare Scholarship Program form? (Check all that apply)
☐ Financial Aid Office ☐ Program Director/Instructor ☐ Foundation office
☐ Foundation Web site ☐ Other Web site ☐ Work (employer/co-worker)
☐ Friend/Acquaintance
Other please specify

### PART F - APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified.

I understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I understand that once submitted my application and supporting documents become the rights of the Health Professions Education Foundation. I also understand that my personal statements become the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Applicant's Signature:	Date:

SPRING POSTMARK DEADLINE: MARCH 24, 2007 FALL POSTMARK DEADLINE: SEPTEMBER 11, 2007

### **SUBMIT APPLICATIONS TO:**

Printed Name: (last name, first name, middle initial)

Health Professions Education Foundation Allied Healthcare Scholarship Program 818 K Street, Suite 210 Sacramento, CA 95814

### APPLICATION CHECKLIST

☐ 1. Official Transcript(s) related to your allied health education
☐ 2. Personal Statements
☐ 3. Two (2) Letters of Recommendation
☐ 4. Graduation Date Verification Form
☐ 5. Resume (optional)
☐ 6. 2007-2008 Student Aid Report (SAR)
or

2006 Federal Tax Return and all W-2s

### **Additional Work History**



Please print legibly or type. Please list all paid and/or unpaid work experience you have had with a maximum of four employers. (resumes will not be used in place of history page.)

Employer's Name:	Employer's Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
County:	County:
Your Supervisor's Name: Office Phone:	Your Supervisor's Name: Office Phone:
Your Position/title: Monthly Salary:	Your Position/title: Monthly Salary:
□ Paid worker OR □ Non paid □ Full-time OR □ Part-time	□Paid worker OR □Non paid □Full-time OR □Part-time
Employment Start Date:// Employment End Date://_	Employment Start Date:// Employment End Date:/_/_
Average hours worked (please choose only one):/day/week/ month	Average hours worked (please choose only one):/day/week/ month
Brief description of your job duties:	Brief description of your job duties:
Employer's Name	Employer's Name
Employer's Name:	Employer's Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
County:	County:
Your Supervisor's Name: Office Phone:	Your Supervisor's Name: Office Phone:
Your Position/title: Monthly Salary:	Your Position/title: Monthly Salary:
□ Paid worker OR □ Non paid □ Full-time OR □ Part-time	□Paid worker OR □Non paid □Full-time OR □Part-time
Employment Start Date:/_/ Employment End Date:/_/_	Employment Start Date:// Employment End Date://_
Average hours worked (please choose only one):/day/week/ month	Average hours worked (please choose only one):/day/week/ month
Brief description of your job duties:	Brief description of your job duties:

### **GRADUATION DATE VERIFICATION FORM**

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is

\*Must be completed by the Program Director or the director's designee.

required for the application to be	e considered. Please return	n this form to the Founda	tion with original signature.
Applicant's Name:			
Allied Healthcare Specialty:			
School:			
Address:			
City:	County:		State: Zip:
Year Entered: Month/Year	Expected Graduati	ion Date: Month/Year	
Enrollment Status: Full-time □	Part-time □	# of units curre	ently enrolled:
This form was completed by			
Name: (Please Print)		Title:	
Signature:		Date:	
Phone Number: ( )			
Please check one:     I certify that I am the   I certify that I am aut	e Program Director. thorized to sign this docum	ent on behalf of the Prod	ram Director.



818 K Street, Suite 210 Sacramento, CA 95814 www.healthprofessions.ca.gov (800) 773-1669

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